Darren Mickell

Appeal of Denied Application for
Total and Permanent Disability Benefits

Exhibit "18"

RBM 05/14/2015

Bert Bell/Pete Rozelle NFL Player Retirement Plan
200 Saint Paul Street • Suite 2420 • Baltimore, Maryland 21202-2008
410-685-5069 • 800-638-3186 • Fax 410-783-0041

Total & Permanent Disability Benefits

PHYSICIAN'S REPORT FORM

Notice to Physician: To preserve your independence and the integrity of the decision-making process, you must avoid contacts with attorneys or other representatives of the player seeking disability benefits from the Bert Bell/Pete Rozelle NFL Player Retirement Plan. Please notify Rose Mary Eves or Paul Scott at the Plan Office (Tel. No. (800)638-3186) if you are contacted by any of these individuals.

To Be Completed By Plan Office:

1. Player's Name *Darren Mickell* Date of Birth [redacted]/1970
2. Address *9250 Chelsea Dr, Miramar, FL 33025*
3. Credited Seasons *1992-1997, 1999-2000* Telephone *(786)277-5788 M*

4. When did you first examine the player? 8/20/2014
5. Have you or have any of your partners ever treated the player? Yes _____ No X
6. What is the nature of the impairment? COGNITION / PSYCHOLOGICAL HEALTH
7. Impairment Information (attach additional sheets if necessary)

Impairment to:	Impairment results from:	Has the impairment persisted or is it expected to perist for at least 12 months from the date of its occurrence?
BRAIN	☐ Illness ☐ Injury ☒ Unknown	☐ Yes ☐ No ☒ Cannot be determined
	☐ Illness ☐ Injury ☐ Unknown	☐ Yes ☐ No ☐ Cannot be determined
	☐ Illness ☐ Injury ☐ Unknown	☐ Yes ☐ No ☐ Cannot be determined
	☐ Illness ☐ Injury ☐ Unknown	☐ Yes ☐ No ☐ Cannot be determined

Stephen N. Macciocchi, PhD., A
(Neutral Neuro-Psychologist)

RBM 05/14/2015

8. In your opinion, is the patient totally disabled to the extent that he is substantially unable to engage in any occupation for remuneration or profit?

Yes_____ No X NOT FROM COGNITIVE PERSPECTIVE

If you checked Yes:

- Specify the medical conditions and how these conditions prevent the Player from working.

_____

- How long do you estimate the Player will be unable to be gainfully employed at any occupation? _____

_____

If you checked No:

- In what type of employment can he engage?

HE CURRENTLY WKS WITH FRIEND 3 DAYS PER WEEK — NOT COGNITIVELY DEMANDING

9. Additional remarks by physician PLAYER MAY HAVE MEDICAL IMPAIRMENT AND PSYCHIATRIC CONDITIONS WHICH MERIT ASSESSMENT

Please attach the required Medical Report with this form.

Physician's Name (typed or printed): *Stephen N. Macciocchi, PhD., ABPP*

Address *Peachtree Dunwoody Pavilion*
5775 Peachtree Dunwoody Road
Building C, Suite 200
Atlanta, GA 30342

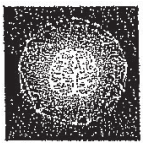
Telephone *(404)556-0752*

I certify that I have personally examined this Player and have personally reviewed any and all records of this Player given to me, and have personally reviewed the attached narrative reports. I also certify that my ratings and comments reflect my best professional judgment, and that I am not biased toward or against this Player.

Signature _____ Examination Date 8/20/2014

Mail completed form with your narrative report to Rose Mary Eves at the Bert Bell/Pete Rozelle NFL Player Retirement Plan, 200 St. Paul Place, Suite 2420, Baltimore, MD 21202-2040.

RBM 05/14/2015



ATLANTA NEUROPSYCHOLOGY LLC
Stephen N. Macciocchi, Ph.D. ABPP
Board Certified in Clinical Neuropsychology
American Board of Clinical Neuropsychology
P.O. Box 550045
Atlanta, Georgia 30355

NEUROPSYCHOLOGICAL ASSESSMENT

NAME:	Darren Mickell
AGE:	44
EDUCATION:	15
PSYCHOMETRICIAN:	Jill Dermeyer, MA
ASSESSMENT DATE:	8/20/2014
REFERRAL SOURCE:	Paul Scott: NFLPBP

REFERRAL INFORMATION:

Darren Mickell is applying for NFL Total and Permanent (TP) disability benefits secondary to multiple orthopedic injuries as well as "headaches, concentration problems, word loss, focus issues and processing issues", reportedly sustained while playing in the NFL. The NFL Player Benefits Program (NFLPBP) requested an assessment in order to document Mr. Mickell's cognitive and psychological functioning in the context of his self-reported health problems.

Prior to the examination, the NFLPBP forwarded Mr. Mickell's NFL TP benefits application and medical records documenting orthopedic injuries, including an IME completed by Craig Lichtblau, M. D. on 3/31/2014. Also included was a neuropsychological assessment completed by Mark Todd, Ph.D. in April 2014. Prior to the examination, Mr. Mickell's attorney Mindy Chmielarz forwarded medical records, which also contained both examinations cited above. Information related to Mr. Mickell's musculoskeletal injuries and associated pain as well as his history of concussions and cognitive problems was also obtained via interview with Mr. Mickell during the examination.

The current examination was focused on Mr. Mickell's neuropsychological functioning. Information extracted from medical records focused on injuries and risk factors for cognitive and psychological health problems. Mr. Mickell's physical injuries and physical symptoms are beyond the scope of the current assessment and the expertise of the current examiner, except to the extent his physical injuries and symptoms affect his psychological and/or cognitive functioning. Persons interested in comprehensive documentation of Mr. Mickell's medical problems and associated treatment should consult primary medical records.

Prior to beginning the examination, Mr. Mickell was educated regarding the nature, purpose and conditions of the current assessment. Mr. Mickell was informed orally and in writing that optimal effort and engagement in testing during the examination was critical for obtaining valid neuropsychological test results. Mr. Mickell was also informed he would not receive a copy of his report from the examiner and he was encouraged to consult the NFLPB program to determine opportunities for obtaining a report and being provided feedback on his assessment. Mr. Mickell evidenced understanding of the nature, purpose and conditions of the assessment and he agreed verbally and in writing to have a summary report of test findings forwarded to Paul Scott at the NFLPBP.

RBM 05/14/2015

NAME: Mickell, D.

HISTORY:

Medical:

According to Mr. Mickell, he has no history of significant childhood, adolescent or adult medical illnesses, other than injuries sustained while playing in the NFL

Mr. Mickell reported sustaining a number of musculoskeletal injuries during his career in the NFL, which are documented in his benefits application and medical records (see IME by Craig Lichtblau, M.D.). Mr. Mickell reports currently experiencing pain in multiple sites, especially his knees, back and hips. He takes OTC anti-inflammatory medication and intermittently is prescribed oxycontin for pain. Mr. Mickell reported his orthopedic IME completed as part of the NFLBP was "very short, like a sideline examination" and did not address his physical injuries adequately. Dr. Lichtblau concluded that Mr. Mickell was "unable to maintain gainful employment" secondary to chronic pain.

Neurological:

According to Mr. Mickell, he had no history of cognitive-developmental disorder in childhood. He also denied a history of neurological trauma-disease in childhood, adolescence and adulthood, except for concussive injuries sustained while playing in the NFL.

Mr. Mickell reported sustaining 2 concussions that he could recall. These injuries occurred during his 2nd and 3rd year in Kansas City. He reported experiencing confusion and headaches and being removed from practice for several days. He also sustained several head contact injuries that resulted in him sitting out several plays.

Mr. Mickell also reported experiencing numerous head contact injuries during his time in the NFL that resulted in brief changes in mental status and visual processing (seeing stars). Mr. Mickell reported these injuries were frequent and that he believed them to be a normal consequence of contact. He did not seek medical attention for any of these head contact injuries or the symptoms following his injuries.

Psychiatric:

Mr. Mickell denied a history of past psychiatric diagnoses, but he reported a period of significant weight loss (30 lbs) and apathy. Mr. Mickell reported that at times he feels depressed, but has not consulted a psychiatric healthcare professional until recently when he was examined by Dr. Todd. He reported he is able to consult with Dr. Todd regarding his psychological health via an NFL sponsored program.

Mr. Mickell also reported experiencing anxiety, which appeared to reflect panic symptoms such as increased heart rate, fears of dying and general anxiety that last for brief periods of time and resolve secondary to going outside.

Dr. Todd reported Mr. Mickell was experiencing "marked anxiety and depression" based on the MMPI-IRF, a short form of the MMPI. Dr. Todd reported collateral evidence of depression based on Mr. Mickell's self-report and his functioning at home.

Mr. Mickell's had a history of cocaine use, which resulted in him being suspended from the NFL for one year. He denied using cocaine after his one year suspension from the NFL. Mr. Mickell reported using marijuana 3-4 times per week to treat his pain. He reported THC is effective in reducing his pain to manageable levels.

RBM 05/14/2015

NAME: Mickell, D.

Neuropsychological:

Dr. Todd completed a neuropsychological examination over 3 sessions in April 2014. His report summarizes Mr. Mickell's performance. According to Dr. Todd, his examination "provided evidence of a mild cognitive disorder" (see page 14). Dr. Todd did not discuss how he reached his clinical conclusion given that many test scores were average and more proficient than Mr. Mickell's general level of intellectual functioning. There was no discussion of base rates of expected low scores given the number of tests administered or Mr. Mickell's level of intellectual functioning. In addition, Dr. Todd reported Mr. Mickell's "motivation" [effort] during testing was good, but he did not provide test scores supporting optimal effort. Finally, Dr. Todd made a number of relevant recommendations regarding Mr. Mickell's physical and psychological health (see page 14-15).

Educational-Psychosocial-Occupational:

Mr. Mickell was born in Miami, Florida and he attended the University of Florida. Mr. Mickell left college before graduation and had an 8 year career in the NFL playing for several teams. He retired from the NFL in 2000. Since retiring from the NFL, Mr. Mickell has worked in a warehouse and his most recent job involves working with a friend supplying video games to various establishments, which he does several days per week. He currently resides with his great grandmother, girlfriend and daughter in Miramar Florida.

TESTS ADMINISTERED:

In order to assess Mr. Mickell' current neuropsychological and psychological functioning, a number of techniques were administered including tests assessing general intellectual skills, problem solving, attention - concentration, language skills, and memory functions. Performance validity testing and a psychological assessment were also administered.

Test interpretation is based on normative data contained in manuals for each test administered unless the test is a component of the co-normed data base published by Heaton, Miller, Taylor, and Grant (2004). Performance descriptors used in the report are based on T Scores, which are standard scores described in the table described below. These performance descriptors may be found in various sources including Heaton, Miller, Taylor and Grant (2004) and Strauss, Sherman and Spreen (2006).

T SCORE	CLASSIFICATION	T SCORE	CLASSIFICATION
70-77	VERY SUPERIOR	35-39	MILD IMPAIRMENT
64-69	SUPERIOR	30-34	MILD-MODERATE IMPAIRMENT
56-63	HIGH AVERAGE	25-29	MODERATE
45-55	AVERAGE	20-24	MODERATE-SEVERE IMPAIRMENT
40-44	LOW AVERAGE	<20	SEVERE IMPAIRMENT

Wechsler Adult Intelligence Scale - IV (WAIS-IV)
Test of Pre-morbid Functioning (TOPF)
Wisconsin Card Sorting Test (WCST)
Delis-Kaplan (DKEFS)
  Trail Making
  Verbal Fluency
  Color-Word Interference

RBM 05/14/2015

NAME: Mickell, D.

Grooved Pegboard Test (GPT)
Boston Naming Test (BNT)
Wechsler Memory Scale - IV (WMS-IV)
Logical Memory I and II
California Verbal Learning Test – II (CVLT-II)
Performance Validity Tests
Minnesota Multiphasic Personality Inventory-2/RF (MMPI-2RF)
Beck Depression Inventory (BDI)
Beck Anxiety Inventory (BAI)
Clinical Interview

TEST RESULTS:

Behavioral Observations and Clinical Interview:

During testing, Mr. Mickell was easily engaged, friendly and appropriate. He appeared relaxed and cooperated fully, but was somewhat apathetic. He worked at a medium pace and generally in a planned and deliberate manner. He persisted on difficult tasks. He did not overtly respond to either success or failure on test items. He increased his effort in response to encouragement.

During interview, Mr. Mickell was alert, oriented, and cooperative. His affect was normal in range and appropriate to content. Mr. Mickell had an adequate understanding of his current medical condition as reflected in his ability to discuss his injuries and relate his current attending physicians' recommendations.

In terms of current cognitive complaints, Mr. Mickell reported having memory and concentration problems. He described forgetting normal responsibilities and having trouble recalling information in day to day activities. He forgets where is going at times. He also misplaces things and reported his thinking is "off". Mr. Mickell also reported having anger problems and being disengaged from his friends and family.

Mr. Mickell did not evidence any significant neurobehavioral symptoms such as disinhibition, aggression, emotional lability or apathy. He also did not evidence any significant neuropsychiatric symptoms such as hallucinations, delusions or compulsions, but he was tearful when describing his inability to function physically and his concerns about his neurological health.

Performance Validity:

Mr. Mickell' performance was impaired on all 3 trials of 2 free standing performance validity measures (6 impaired scores). His performance was also impaired on 1 embedded validity measure, but unimpaired on another. Overall, his effort during the current examination as indexed by validity metrics was impaired to the point that his test performance level would be negatively impacted, particularly on memory tests.

Intelligence:

Mr. Mickell's Verbal Comprehension Index on the Wechsler Adult Intelligence Scale - IV was low average (87). Mr. Mickell's Perceptual Reasoning Index was average (90).

Mr. Mickell's Full Scale IQ Score on the WAIS-IV was low average (83). His performance on the WAIS-IV was generally consistent with, but less proficient than his predicted Full Scale IQ Score estimate based on the Test of Pre-Morbid Functioning (89).

RBM 05/14/2015

NAME: Mickell, D.

Executive Functions:

Mr. Mickell's attribute identification and set shifting on the Wisconsin Card Sorting Test was uniformly average to high average (Errors/T=53; Perseverative Responses/T=57; Perseverative Errors/ T=57; Non-Perseverative Errors/T=48; and Categories (6) T=50+).

Mr. Mickell's performance on the D-KEFS Trail Making Test ranged from low average to average (Visual Scanning/T=43; Letter-Number Switching/T=43) to average (Number-Sequencing/T=53; Letter Sequencing/T=50).

Mr. Mickell's performance on the D-KEFS Color-Word Test was average to high average (Color Naming/T=56; Word Reading/T=46; Inhibition/T=50 and Inhibition-Switching/T=46).

Attention-Concentration:

Mr. Mickell' performance on the Wechsler Adult Intelligence Scale - IV documented a Working Memory Index that fell in the mildly impaired range (74). In contrast, his Processing Speed Index was average (92).

Motor Functions:

Mr. Mickell's motor speed on the D-KEFS was average (T=53). Mr. Mickell's dominant (right) fine motor speed and dexterity on the Grooved Pegboard Test was mildly impaired (T=35). Mr. Mickell's non-dominant fine motor speed and dexterity was mildly-moderately impaired (T=34).

Language Functions:

Mr. Mickell' speech was fluent with no evidence of paraphasias or dysnomia. His narrative and discourse was logical and coherent. His prosody was normal. Mr. Mickell' confrontation Naming on the Boston Naming Test was low average (T=43). His verbal fluency on the D-KEFS was generally average (Category Switching/T=46; Category Fluency/T=43 and Letter Fluency/T=46).

Memory Functions:

Mr. Mickell's story memory performance on the Wechsler Memory Scale - IV was mildly-moderately impaired following a short delay (T=33) and moderately impaired following a long delay (T=22).

Mr. Mickell's verbal learning over trials on the California Verbal Learning Test-II was low average (T=40). His short delayed spontaneous recall was mildly impaired (T=35). His long delayed spontaneous recall was low average (T=40).

Psychological Functioning:

Mr. Mickell' responses on the MMPI-2-RF revealed an elevation =/> T=80 on 4 validity scales (Infrequent Responses/T=97; Infrequent Somatic Responses/T=83; Symptom Validity/T=92 and Response Bias Scale/ T=105). Scales assessing reliability of responding (VRIN/T=43 and TRIN/T=57) were not elevated.

In terms of Higher Order, Restructured Clinical and Somatic-Cognitive scales, Mr. Mickell had 6 elevations equal to or > T=80 (Somatic Complaints Scale/T=90; Malaise/T=81; Neurological Complaints/T=96; Head Pain Complaints/T=85; Cognitive Complaints/T=91 and Anxiety/T=80).

On the BDI Mr. Mickell's score (29) was consistent with severe depressive symptoms. Mr. Mickell also reported symptoms of severe anxiety on the Beck Anxiety Inventory (30).

RBM 05/14/2015

NAME: Mickell, D.

According to MMPI-2RF interpretive guidelines (Ben-Porath, 2012), when there is no evidence of inconsistent responding (elevated VRIN-r and TRIN-r), Mr. Mickell's elevations on 4 validity scales makes interpretation of Higher Order, Restructured and Somatic-Cognitive Scales difficult due to symptom over-reporting. In the absence of symptom validity and response bias concerns, Mr. Mickell's MMPI-2-RF, BDI and BAI primarily reflect concerns about his physical and neurological health, as well as anxiety and depression, which is consistent with his self-report regarding concerns about his cognitive and physical functioning.

IMPRESSION:

Darren Mickell has a history of chronic pain, which is a risk factor for cognitive inefficiency. He also reports symptoms of anxiety and depressive disorders, which are also risk factors for cognitive inefficiency, although the severity his psychological health disorders are difficult to determine due to symptom over-reporting. Nonetheless, he has a self-reported history of significant weight loss, apathy, social isolation and panic symptoms. Whether his use of THC for pain relief has had an impact on his cognitive functioning is not entirely clear since research has not definitively shown that THC use has a chronic, deleterious effect on cognition.

Mr. Mickell also has a history of what he reported to be at least 2 concussions and he reportedly experienced numerous other head contact injuries during his time in the NFL that resulted in transitory changes in mental status. The long term impact of multiple concussive injuries on cognitive functioning has not been extensively studied, despite recent, appropriate attention to the effects of these injuries. Consequently, based on existing science, determining the effect head contact injuries have on individual NFL players cognitive functioning is difficult if not impossible to quantify, except when there is evidence of a reliable decline in cognitive functioning over a sustained period of time documented by valid neurocognitive test performance. These findings would need to be obtained in the absence of other more common disorders known to have a negative impact on cognition such as pain, sleep and psychiatric disorders as well as unreliable test findings due to suboptimal effort or malingering. In any case, media reporting of single case studies and other anecdotal evidence regarding the effect of multiple concussions has raised concerns about neurological health among many athletes, not just NFL players. Consequently, NFL players are experiencing reasonable anxiety regarding their neurological health. Anxiety is known to negatively impact cognitive efficiency and result in the subjective experience of cognitive dysfunction.

For instance, in terms of psychological health, Mr. Mickell reports symptoms of major depression and panic disorder in part related to his concerns about his health. He is considerably worried about his physical and neurological health. He reports changes in behavior and mood that have affected his everyday functioning. While there is self-report evidence Mr. Mickell is experiencing symptoms of major depression, and panic disorder, his MMPI-2RF is difficult to interpret due to symptom over-reporting on validity metrics, which raises concerns about the reliability of any self-report measures that do not have embedded symptom validity scales such as the BDI and BAI. Consequently, even though Mr. Mickell reports numerous clinically suggestive psychological health problems, the severity of his psychological health problems and implications for his ability to engage in competitive employment remains to be determined.

In terms of cognitive complaints, Mr. Mickell's scores on performance validity measures were impaired. Impaired scores on performance validity metrics have been shown to be strongly associated with lowered neuropsychological test performance. In other words, research has shown that persons who evidence impaired scores on freestanding performance validity measures score much lower on neuropsychological tests compared to cohorts with similar medical histories who perform well on performance validity tests (above empirically established

RBM 05/14/2015

cutoffs). Consequently, Mr. Mickell is most likely functioning at a higher cognitive level than was documented during his current examination. Nevertheless, Mr. Mickell did not evidence other signs of performance invalidity, such as pervasively impaired neuropsychological test performance that deviates from known patterns of brain functioning, other than in the area of memory functioning.

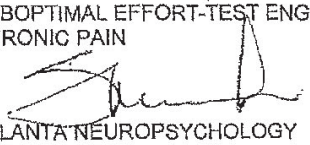
In other words, despite concerns about performance validity during the current assessment, Mr. Mickell did not evidence an abnormal number of low scores. Presuming Mr. Mickell's predicted Full Scale IQ on the TOPF is accurate, research has shown that 78% of persons with low average IQ in standardization samples have 5 or more scores fall below T=40 when administered neuropsychological batteries with 36 scores. The current test battery has approximately 60 scores and Mr. Mickell had 6 scores that fell below T=40, which is not psychometrically or statistically unexpected, especially given concerns about performance validity. More importantly, when focusing on skills necessary for day to day and employment functioning such as processing speed and executive skills, Mr. Mickell performed in the average to high average range.

In contrast, Mr. Mickell's memory test performance was less proficient during the current examination and more impaired relative to his performance 4 months ago. When comparing Mr. Mickell's current memory test scores with his previous examination completed 4 months ago, his memory test performance declined significantly on story memory tasks, but improved on list learning tasks. His decline in story memory over such a brief period of time is most likely due to performance validity problems and/or exacerbation of psychiatric symptomatology.

In summary, there are questions regarding the reliability and validity of Mr. Mickell's neurocognitive and psychological health test findings. Despite concerns about the reliability and validity of neurocognitive test scores, Mr. Mickell did not evidence an abnormal number of impaired scores compared to expectations derived from normative data bases. He did evidence a decline in memory test performance over the past 4 months, which cannot be explained by declining neurological health, but may be due to psychiatric problems and/or suboptimal engagement on memory tests during the current examination. Even when considering validity issues, there is no current psychometric evidence Mr. Mickell cannot engage in gainful employment solely from a cognitive perspective. Whether Mr. Mickell's medical problems such as chronic pain or a psychiatric disorder, most likely major depression and panic disorder, would prevent him from working cannot be definitively determined by the current examination. There is clinically suggestive evidence he may have a major depressive disorder and a panic disorder, which could impair his ability to secure and maintain successful employment. Consequently, Mr. Mickell will need formal medical and psychiatric examinations to assess the reliability and significance of his physical/pain disorders and psychiatric condition. If obtained, a psychiatric examination must consider symptom validity and response bias in the context of any self-reported symptoms.

DIAGNOSITIC CONSIDERATIONS:

R/O MAJOR DEPRESSION, MILD - MODERATE (DSM-V: 296.21-296.22)
R/O PANIC DISORDER (DSM-V: 300.01)
SUBOPTIMAL EFFORT-TEST ENGAGEMENT
CHRONIC PAIN



ATLANTA NEUROPSYCHOLOGY
STEPHEN MACCIOCCCHI, PH.D. ABPP, MEMBER

RBM 05/14/2015

NFL NEUROPSYCHOLOGICAL TEST BATTERY

Name: Derren Mickell

Date: 8/20/2014

TEST	Raw Score	T Score	%ile	Interpretation
Premorbid Intellectual Functioning				
TOPF Estimate IQ	29	42	23	Low Average
EFFORT				
CVLT-II Forced Choice Recognition (#)	93.8	n/a	n/a	
MSVT (% correct IR, DR, CNS)	60, 65, 65	n/a	n/a	Below Expectations
Reliable Digit Span (#)	6	n/a	n/a	Below Expectations
Test of Memory Malingering (%correct)	60	n/a		Below Expectations
Intellectual Functioning				
WAIS-IV FSIQ	83	38	13	Mild
WAIS-IV VCI	87	41	19	Low Average
WAIS-IV PRI	90	43	25	Low Average
WAIS-IV WMI	74	33	4	Mild/Moderate
WAIS-IV PSI	92	44	30	Low Average
Vocabulary	29	43	25	Low Average
Information	8	16	40	Low Average
Similarities	21	25	43	Low Average
Arithmetic	13	37	46	Average
Digit Span	12	22	0.4	Moderate/Severe
Block Design	43	50	50	Average
Visual Puzzles	10	16	40	Low Average
Coding	60	25	43	Low Average
Matrix Reasoning	14	25	43	Low Average
Symbol Search	31	37	46	Average
LANGUAGE				
Boston Naming Test	7	43	24	Low Average
DKEFS Letter Fluency	34	46	37	Average
Category Fluency	36	43	25	Low Average

RBM 05/14/2015

TEST	Raw Score	T Score	%ile	Interpretation
Category Switching Total Correct	13	46	37	Average
ATTENTION				
WAIS IV Digit Span	2	22	0.4	Moderate/Severe
WMS IV Symbol Span	14	36	9	Mild
MOTOR SPEED				
WAIS IV PSI	92	44	30	Low Average
GP Dominant Hand	102	35	7	Mild
GP Non Dominant Hand	112	34	5	Mild/Moderate
DKEFS Motor Speed	27	53	63	Average
VISUAL PERCETUAL SKILLS				
WMS IV Visual Reproduction Copy	Not Administered			
Rey Copy	Not Administered			
WAIS IV Block Design	10	50	50	Average
VERBAL MEMORY/LEARNING				
CVLT II Trial 1	5	-1.0	16	Low Average
Trial 5	9	-1.5	6	Mild/Moderate
Sum Trials 1-5	39	40	16	Low Average
Short Delay Free Recall	6	-1.5	6	Mild/Moderate
Long Delay Free Recall	9	-1.0	16	Low Average
Learning Slope	1.1	-0.5	30	Low Average
Repetitions	7	1.0	84	High Average
Intrusions	6	1.0	84	High Average
WMS-IV Logical Memory I	14	33	5	Mild/Moderate
Logical Memory II	9	22	2	Moderate/Severe
VISUAL MEMORY				
WMS IV Visual Reproduction I				
Visual Reproduction II				
Visual Reproduction Recognition				

RBM 05/14/2015

TEST	Raw Score	T Score	%ile	Interpretation
EXECUTIVE FUNCTIONING				
DKEFS Visual Scanning	38	43	25	Low Average
Number Sequencing	30	53	63	Average
Letter Sequencing	34	50	50	Average
Number Letter Switching	102	43	25	Low Average
Motor Speed	27	53	63	Average
WCST Total Errors	13	53	62	Average
Perseverative Responses	4	57	76	High Average
Perseverative Errors	4	57	76	High Average
Non-Perseverative Errors	9	48	42	Average
Conceptual Level responses	82	n/a	n/a	n/a
Categories Completed (#)	6	n/a	>16	Average
Trials to 1st Category (#)	11	n/a	>16	Average
Failure to Maintain Set (#)	2	n/a	6-10	Mild/Moderate
Learning To Learn (#)	-1.34	n/a	>16	Average
DKEFS Color Naming	25	66	75	High Average
Word Reading	23	46	34	Average
Inhibition	56	10	50	Average
Inhibition/Switching	65	46	37	Average
WAIS IV Similarities	8	43	25	Low Average
Matrix Reasoning	14	43	25	Low Average
PERSONALITY/MOOD				
BDI	29			Severe
BAI	30			Severe

RBM 05/14/2015

MMPI-2-RF T SCORES (BY DOMAIN)

PROTOCOL VALIDITY

Content Non-Responsiveness

CNS	VRIN-r	TRIN-r
0	43	57 T

Over-Reporting

F-r	Fp-r	Fs	FBS-r	RBS
97	59	83	92	105

Under-Reporting

L-r	K-r
52	42

SUBSTANTIVE SCALES

Somatic/Cognitive Dysfunction

RC1	MLS	GIC	HPC	NUC	COG
90	81	64	85	96	91

Emotional Dysfunction

EID	RCd	SUI	HLP	SFD	NFC
76	77	45	60	65	64

RC2	INTR-r
73	70

RC7	STW	AXY	ANP	BRF	MSF	NEGE-r
65	73	80	73	63	54	80

Thought Dysfunction

THD	RC6	RCR	PSYC-r
67	70	76	66

Behavioral Dysfunction

BXD	RC4	JCP	SUB
55	57	57	61

RC9	AGG	ACT	AGGR-r	DISC-r
48	56	48	41	59

Interpersonal Functioning

EML	RC3	IPP	SAV	SHY	DSF
58	43	62	65	57	44

Interests

AES	MEC
33	52

Note. This information is provided to facilitate interpretation following the recommended structure for MMPI-2-RF interpretation in Chapter 5 of the *MMPI-2-RF Manual for Administration, Scoring, and Interpretation*, which provides details in the text and an outline in Table 5-1.

RBM 05/14/2015

Darren Mickell

Appeal of Denied Application for
Total and Permanent Disability Benefits

Exhibit "19"

RBM 05/14/2015

COMPREHENSIVE REHABILITATION EVALUATION

Containing

Independent Medical Evaluation
Medical Functional Capacity Assessment
AMA Impairment Rating
Functional Capacity Assessment
Summary
Photographs

On

Darren Mickell

Prepared by:

Craig H. Lichtblau, M.D.
Board Certified Physical Medicine & Rehabilitation
Fellow, American Academy of Disability Evaluating Physician

RBM 05/14/2015

Independent Medical Evaluation

RBM 05/14/2015

CRAIG H. LICHTBLAU, M.D., P.A.

PHYSICAL MEDICINE AND REHABILITATION
BOARD CERTIFIED
PEDIATRIC • ADOLESCENT • ADULT • GERIATRIC

550 Northlake Boulevard
North Palm Beach, Florida 33408-5409
Phone: (561) 842-3694
Facsimile: (561) 842-3774

Outpatient Physical Medicine
Inpatient Rehabilitation
Medical Functional Capacity Exams
Nationwide Catastrophic Evaluations

Mindy Chmielarz, Esquire
DI Law Group
4151 Hollywood Boulevard
Hollywood, FL 33021

Independent Medical Evaluation

Date: 03/31/14
Patient: Darren Mickell
Chart #: 33900
DOB: [redacted]70
Date of Injury: 1992-2001

History of Present Illness:
This is a 43-year-old, right-hand-dominant African-American male, who played professional football for the National Football League from 1992 to 2001. The patient states he played on several different teams, including Kansas City, New Orleans, San Diego, and Oakland. The patient states he has sustained multiple injuries throughout his career and continued to play for as long as possible. The patient states his first injury was in 1994 to both of his knees while playing for Kansas City. He states he never had an MRI or x-rays, but was given other treatments to alleviate his pain to keep him playing in the game. The patient states, by the end of the season, he wound up having surgery on both of his knees.

The patient had arthroscopic surgery to both knees between 1994 and 1995. The patient states after one of his arthroscopic knee surgeries, he began having lower back pain, which he states at that point was worse than his knee pain. The patient states he was given some type of injection in his back (probable epidural) prior to his surgery.

RBM 05/14/2015

The patient states in 1996 he had surgery on his right shoulder. He states he required the surgery, secondary to injuries sustained during the years he played with New Orleans.

The patient states in 1999 he injured his left hip while playing for San Diego. The patient states he followed up with a physician, who drained his hip several times, but he continued to have pain, which got worse when he continued to play.

He states throughout the last two years of his professional career in the NFL, he was given cortisone injections and other pain injections to alleviate his pain in his back, knees, and hips so that he would be able to continue to play. He states he was prescribed anti-inflammatory medications that he took on a daily basis. The patient states by the end of 2000, he had to stop playing football due to the multiple injuries and ongoing pain and limitations he sustained.

The patient states he began to notice that he had been having issues with his cognition, secondary to playing football for many years. The patient states he began having noticeable short-term memory loss, difficulty concentrating, problems controlling his emotions, and chronic headaches.

The patient states he had been unable to work in any capacity, secondary to his constant headaches and ongoing pain to his shoulders, back, hip, and knees. The patient states his pain continued to get progressively worse over the years to the point where he had great difficulty just getting through the day. The patient states, because of his financial situation, he just had no choice but to find employment. He states he attempted to work for about a year and a half as a freight handler, but finally had to stop due to his pain, decreased functional ability, weakness, and cognitive limitations.

Presently, the patient states he has been having continued daily headaches, which can go as high as 8 out of 10 on the 1-10 scale for pain. He states the headaches seem to start from the back of his head and radiate upwards. He states the headaches can last for several hours at a time. He states he will take Aleve or Advil, which sometimes helps to temporarily alleviate the headaches. He states he has associated nausea and dizziness at times when he has these headaches. He denies visual changes. He states he is having continued problems with his short-term memory, concentration, and attention. He states he has difficulty finding the right words to say at times in conversation. He states he has difficulty processing information and following directions.

The patient states he has been having neck pain as well, described as 8 out of 10 on the 1-10 scale for pain. He states keeping his head in any position other than neutral exacerbates his neck pain. He states an increase in activity can exacerbate his neck pain as well. He states he is having intermittent numbness and tingling sensations into both hands.

RBM 05/14/2015

He states he is having continued pain radiating into both of his shoulders, left greater than right. He describes his left shoulder pain as a constant 6 out of 10 on the 1-10 scale for pain. He states at times his pain level goes as high as 9 out of 10. He states he is having continuous right shoulder pain, described as 5 to 6 out of 10 on the 1-10 scale for pain. He states at times, with increased activity, his right shoulder pain can go as high as 8 out of 10. He states overhead activity and lifting really tend to exacerbate his pain.

He states he is having frequent pain in his left hip, described as 5 out of 10 on the 1-10 scale for pain. He states at times his pain level in his left hip can go as high as 9 to 10 out of 10. He states the pain would usually get as high as 9 to 10 when he had been working. He states he has frequent popping and clicking sensations and pain radiating towards his groin region on the left.

He states he is having pain in both of his knees. He describes his left knee pain as a constant 6 out of 10 on the 1-10 scale for pain. He states at times his left knee pain goes as high as 10 out of 10. He states he is having constant right knee pain, described as 6 out of 10 on the 1-10 scale for pain. He states at times his right knee pain can also go as high as 10 out of 10. He states his left knee swells up frequently and has stiffness. He states his knees will lock up at times. He states he uses ice, Advil, or Aleve, which helps to temporarily alleviate some pain. He states he will also rest and elevate his lower extremities if he is having an increased amount of pain.

He states he is having constant lower back pain, described as 5 out of 10 on the 1-10 scale for pain. He states at times his pain level goes as high as 9 out of 10. He states walking for too long and standing for too long can exacerbate his pain. He states he feels weakness into both lower extremities with spasms and stiffness across his lower back. He states sitting for too long, standing for too long, bending, twisting, turning, and lifting can exacerbate his pain. He states that he can no longer maintain an erection with his girlfriend because of the constant pain he has.

The patient states he has been depressed about his current situation.

Past Medical History:
Unremarkable.

Past Surgical History:
Per HPI.

Allergies:
No known drug allergies.

Medications:
Over-the-counter Tylenol and Aleve.

RBM 05/14/2015

Family History:
Mother is living at 63 with history of hypertension. Father deceased at 36 with history of cancer.

Social History:
The patient is single. He has four children. He states he is a nonsmoker and occasionally consumes alcohol. He denies illicit drug use. The patient is currently unemployed, but was playing for the National Football League from 1992 to 2001.

Review of Systems:
CONSTITUTIONAL: Weight gain, weakness, fatigue, and difficulty sleeping. **SKIN:** The patient denies rashes, pruritus, or lesions. **HEAD:** Headaches and dizziness. **EYES:** The patient denies change in visual fields, photophobia, diplopia, inflammation, discharge, or glasses. **EARS, NOSE, MOUTH, AND THROAT:** EARS: The patient denies hearing changes, tinnitus, pain, or discharge. NOSE: The patient denies sinus problems, nose bleeds, or obstructive polyps. THROAT: The patient denies inflammation, lesions, discharge, or hoarseness. MOUTH: The patient denies dentures, lesions, or discharge. **RESPIRATORY:** The patient denies shortness of breath, wheezing, cough, or hemoptysis. **CARDIOVASCULAR:** The patient denies hypertension, chest pain, dyspnea, rheumatic fever, murmurs, orthopnea, cyanosis, edema, claudication, or palpitations. **GASTROINTESTINAL:** The patient denies decreased appetite, dysphagia, nausea, vomiting, hematemesis, indigestion, pain, diarrhea, constipation, melena, or hemorrhoids. **GENITOURINARY:** Increased urination, sexual dysfunction, and thyroid problems. **ENDOCRINE:** The patient denies polyphagia, polydipsia, polyuria, thyroid problems, glycosuria, or hormone therapy. **MUSCULOSKELETAL:** Joint pain, stiffness, and muscle pain. **HEMATOLOGY:** The patient denies anemia, bleeding tendency, easy bruising, or lymphadenopathy. **NEUROPSYCHIATRIC:** Coordination problems, memory changes, dizziness, and emotional disturbance.

Physical Examination:

Constitutional:	**General:** Well-nourished, well-developed male. **Vital Signs:** Stable, afebrile. BP is 120/70. Heart rate is 46. O2 saturation is 99%.
Psychiatric:	Alert and oriented x 3. The patient is in no acute distress. The patient was able to recall 2 out of 3 objects, instant recall, and 0 out of 3 objects in five minutes. The patient had difficulty and had to stop because he had wrong answers performing serial subtractions of 7 starting with a 100.
Skin:	Without scars, masses, lesions, or discharge.
Head:	Atraumatic, normocephalic.
Eyes:	Pupils are equal, round and reactive to light and accommodation. Extraocular movements full. Sclera clear. Ophthalmic examination deferred.

RBM 05/14/2015

Ears/Nose Mouth & Throat:	Ears without discharge. Nose without obstruction. Without lesions or masses. Otoscopic examination deferred. Hearing within functional limits. The patient was able to identify 1 out of 3 smells using a pocket smell test.
Neck:	Without carotid bruits. Neck supple. No masses.
Respiratory:	Auscultation of lungs without adventitious breath sounds. Respiration without use of accessory muscles.
Cardiovascular:	**Heart:** Auscultation of heart reveals S1 and S2. No gallops, murmurs, or heaves. Regular rate and rhythm. **Pulses:** Radial pulse and dorsal pedal pulse 2+ bilaterally.
Gastrointestinal:	Bowel sounds present in all four quadrants. Without rebound tenderness. Without masses.
Musculoskeletal:	**AROM** within functional limits for all joints. **Extremities:** The patient has tenderness to light palpation along his cervical and lumbar paraspinal muscles with palpable spasm in his cervical and lumbar paraspinal muscles and across his trapezius muscles and quadratus lumborum muscles bilaterally. The patient has tenderness to light palpation in the medial and lateral joint lines of both knees. The patient has palpable crepitus with flexion and extension in both knees. The patient has tenderness to light palpation generalized over his shoulders with more exquisite tenderness at his left anterior deltoid region. **Gait:** The patient ambulates with a normal gait, unassisted.
Neurological:	Speech normal. **Cranial Nerves:** II through XII intact. **Deep Tendon Reflexes:** 1+/4 throughout. **Sensory:** Intact to light touch, pinprick, position, and cold sense throughout. **Motor:** 5/5 throughout.

Records Review Index:
Voluminous Records were reviewed. Below is a list of the pertinent records.

1990

12/03/90	Clinic Follow Up, Peter A. Indelicato, M.D., College of Medicine, University of Florida.

1991

08/17/91	Follow Up, Chip Christian, M.D., Peter A. Indelicato, M.D.
08/19/91	MRI Bilateral Knee, Shands Hospital, University of Florida.
08/22/91	Operative Report, Peter A. Indelicato, M.D., Shands Hospital, University of Florida.
08/28/91	Clinic Follow Up, Peter A. Indelicato, M.D., College of Medicine, University of Florida.

RBM 05/14/2015

09/11/91 Clinic Follow Up, Peter A. Indelicato, M.D., College of Medicine, University of Florida.

1992

01/23/92 MRI Left Knee, Shands Hospital, University of Florida.
01/29/92 Clinic Follow Up, Peter A. Indelicato, M.D., College of Medicine, University of Florida.
01/30/92 Office Visit, Jim Jernigan, M.D.
02/14/91 Operative Report, Peter A. Indelicato, M.D., Florida Surgical Center.
02/19/92 Post Op Visit, Peter A. Indelicato, M.D., College of Medicine, University of Florida.
08/19/92 Medical Report, Arthur C. Retting, M.D., Colts.
08/26/92 Medical Report, KC Chiefs, Cris D. Barnthouse, M.D.
09/30/92 Medical Report, Dr. Barnthouse, Arrowhead Stadium.
10/02/92 Notice of Medical Appointment, Kansas City Chiefs.
10/05/92 MRI Left Knee, Richard J. Herzog, M.D., Magnetic Resonance Institute of Greater Kansas City.
10/07/92 Training Room Note, Dr. Browne.
10/12/92 Training Room Note,
10/14/92 Training Room Examination, Dr. Jon Browne.
10/16/92 Notice of Hearing, Paul Tagliabue, Kansas City Chiefs.
10/21/92 Training Room Visit, Dr. Barnthouse.
11/04/92 Training Room Note, Dr. Browne.
11/11/92 Training Room Visit, Dr. Browne.

1993

01/04/93 Final Physical, Dr. Browne.
01/07/93 Letter from Chris Condra, MS, LPC, CONCERN.
04/29/93 XR Chest PA & LAT, Gerald E. Staab, M.D., Radiology Associates, LTD.
05/17/93 Examination, Cris D. Barnthouse, M.D., Orthopaedic and Sports Medicine Clinic of Kansas City, P.A.
07/23/93 Training Camp Note, Cris D. Barnthouse, M.D.
07/27/93 Training Camp Note, Jon E. Browne, M.D.
07/30/93 MRI Right Shoulder, Richard J. Herzog, M.D., MRI of Greater Kansas City.
08/03/93 Training Room Note, Andrew R. Scott, M.D.
08/08/93 Training Camp Note, Cris D. Barnthouse, M.D.
08/21/93 Post Minnesota Game Training Room Note, Dr. Barnthouse.
10/01/93 Notice of Dental Appointment, Kansas City Chiefs.
10/03/93 Post Game L.A. Raiders Game, Dr. Barnthouse.
10/06/93 Training Room Note, Dr. Browne.
11/15/93 Post L.A. Raiders Game, Dr. Barnthouse.
12/26/93 Post Minnesota Game, Dr. Barnthouse.

1994

01/02/94	Post Seattle Seahawks Game, Dr. Barnthouse.
01/03/94	Follow Up, Jon E. Browne, M.D., Orthopaedic and Sports Medicine Clinic of Kansas City, P.A.
01/23/94	Post Buffalo Game, Dr. Browne.
06/01/94	Notice of Dental Appointment, Dave Kendall, Trainer, Kansas City Chiefs.
08/14/94	Post Washington Game, Dr. Cris Barnthouse.
08/22/94	Chicago Bears, Dr. Cris Barnthouse.
08/24/94	Medical Dictation, Dr. Cris Barnthouse.
09/05/94	Post New Orleans Saints Game, Dr. Jon Browne.
09/08/94	Training Room Visit, Dr. Cris Barnthouse.
09/11/94	Post San Francisco Game, Dr. Jon Browne.
09/19/94	Post Atlanta Falcons, Dr. Jon Browne.
09/25/94	Post L.A. Rams Game, Dr. Jon Browne.
10/05/94	Training Room Note, Dr. Cris Barnthouse.
10/09/94	Post San Diego Chargers, Dr. Jon Browne.
10/10/94	Follow Up,
10/12/94	Training Room Note, Dr. Cris Barnthouse.
10/19/94	Training Room Note, Dr. Cris Barnthouse.
10/30/94	Post Buffalo Bills, Dr. Cris Barnthouse.
11/03/94	Training Room Visit, Dr. Cris Barnthouse.
11/13/94	Post San Diego, Dr. Cris Barnthouse.
11/20/94	Post Cleveland Game, Dr. Jon Browne.
11/23/94	Training Room Visit, Dr. Cris Barnthouse.
11/27/94	Post Seattle Game, Dr. Cris Barnthouse.
11/27 thru 11/30/94	Post Seattle Game Training Room Notes, Dr. Cris Barnthouse.
12/04/94	Post Denver Game, Dr. Jon Browne.
12/07/94	Training Room Visit, Dr. Cris Barnthouse.
12/07/94	Training Room Visit, Dr. Scott.
12/12/94	Post Miami Game, Dr. Cris Barnthouse.
12/14/94	Training Room Visit, Dr. Scott.
12/24/94	Post L.A. Raiders, Dr. Jon Browne.

1995

02/13/95	Evaluation, Jon E. Browne, M.D., Orthopaedic and Sports Medicine Clinic of Kansas City, P.A.
02/14/95	MRI Right Wrist, Richard Herzog, M.D., MR Institute of Greater Kansas City.
03/10/95	Follow Up Visit, Jon E. Browne, M.D., Orthopaedic and Sports Medicine Clinic of Kansas City, P.A.
03/22/95	Follow Up Visit, Jon E. Browne, M.D., Orthopaedic and Sports Medicine Clinic of Kansas City, P.A.
04/05/95	Follow Up Visit, Jon E. Browne, M.D., Orthopaedic and Sports Medicine Clinic of Kansas City, P.A.

04/26/95	XR Chest PA & LAT, Gerald E. Staab, M.D., Radiology Associates, Ltd.
07/12/95	Follow UP Visit, Jon E. Browne, M.D., Orthopaedic and Sports Medicine Clinic of Kansas City, P.A.
07/27/95	Training Room Note, Dr. Jon Browne.
08/19/95	Buffalo Bills, Dr. Jon Browne.
09/10/95	Post Giants Game, Dr. Scott.
09/17/95	Post Oakland Raiders Game, Dr. Cris Barnthouse.
09/20/95	Training Room Visit, Dr. Cris Barnthouse.
09/27/95	Training Room Visit, Dr. Scott.
10/01/95	Post Arizona Cardinals, Dr. Cris Barnthouse.
10/05/95	Training Room Exam, Dr. Jon Browne.
10/09/95	Post San Diego Game, Dr. Scott.
10/11/95	Training Room Visit, Dr. Cris Barnthouse.
10/11/95	MRI Left Shoulder, Richard Herzog, M.D., MR Institute of Greater Kansas City.
10/15/95	Post New England Game, Dr. Jon Browne.
10/19/95	Training Room Note, Dr. Cris Barnthouse.
10/24/95	Follow Up Visit, Jon E. Browne, Orthopaedic and Sports Medicine Clinic of Kansas City, P.A.
11/01/95	Training Room Note, Dr. Cris Barnthouse.
11/05/95	Post Washington Redskins, Dr. Cris Barnthouse.
11/08/95	Training Room Visit, Dr. Scott.
11/15/95	Orthopedic Exam – Locker Room Visit, Dr. Cris Barnthouse.
12/11/95	Post Miami Game, Dr. Cris Barnthouse.
12/17/95	Post Denver Game, Dr. Cris Barnthouse.
12/20/95	Training Room Visit, Dr. Cris Barnthouse.
1996	
04/26/96	Examination.
06/04/96	Evaluation, Terry L. Habig, M.D., Southern Orthopaedic Specialists.
08/14/96	Follow Up Visit, Southern Orthopaedic Specialists.
08/21/96	Office Visit, Southern Orthopaedic Specialists.
09/05/96	Office Visit, Southern Orthopaedic Specialists.
09/23/96	Office Visit, Southern Orthopaedic Specialists.
09/24/96	XR Right Elbow, Terry L. Habig, M.D., Southern Orthopaedic Specialists.
11/18/96	Office Visit, Southern Orthopaedic Specialists.
11/18/96	XR Right Elbow, Terry Habig, M.D., Southern Orthopaedic Specialists.
11/25/96	XR Right Foot AP, Lateral & Oblique, Terry L. Habig, M.D., Southern Orthopaedic Specialists.
11/27/96	Office Visit, Southern Orthopaedic Specialists.
12/18/96	Office Visit, Southern Orthopaedic Specialists.

1997
04/28/97 Office Visit, Terry L. Habig, M.D., Southern Orthopedic Specialists.
05/31/97 Office Visit & Telephone Conversation
06/02/97 Evaluation, Terry L. Habig, M.D., Southern Orthopaedic Specialists.
12/10/97 Follow Up, Southern Orthopaedic Specialists.

1998
02/20/98 Office Visit, Terry L. Habig, M.D., Southern Orthopedic Specialists.
03/04/98 Evaluation, Timothy P. Finney, M.D., Southern Orthopaedic Specialists.
06/15/98 Follow Up, Timothy P. Finney, M.D., Southern Orthopaedic Specialists.

1999
09/15/99 Physical Examination, Terry L. Habig, M.D., Southern Orthopaedic Specialists.

2000
01/14/00 History & Physical, San Diego Chargers.
09/08/00 MRI Right Hip, Peter D. Franklin, M.D., Health South Diagnostic Center of San Diego.
10/31/00 MRI Left Shoulder, Peter D. Franklin, M.D., Health South Diagnostic Center of San Diego.

2001
02/05/01 Operative Report, David Chao, M.D., Oasis Health South Surgery Center.
07/29/01 Injury Report, Warren King, M.D., Oakland Raiders Organization.
07/30/01 Follow Up Injury Report, Fred Nicola, M.D., Oakland Raiders Organization.

2011
05/07/11 MRI Cervical Spine, Carlos Rivera, M.D., Open MRI of Miami-Dade, Ltd.

2014
04/05/14 MRI Right Knee W/O Contrast, Andrew T. Walker, M.D., Beaches MRI
04/05/14 MRI Left Knee W/O Contrast, Andrew T. Walker, M.D., Beaches MRI
04/05/14 MRI Left Hip/Pelvis, W/O Contrast, Andrew T. Walker, M.D., Beaches MRI

Pertinent records reviewed are available upon request.

-END OF RECORDS REVIEW INDEX-

RBM 05/14/2015

Diagnostic Impression:

1. Cervical and lumbar myofascial pain, secondary to multiple injuries sustained while playing for the National Football League from 1992 to 2001.
2. History of chronic headaches, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.
3. Probable traumatic brain injuries with subsequent chronic posttraumatic headaches and cognitive deficits, secondary to injuries sustained from playing football for the National Football League from 1992 to 2001.
4. Bilateral shoulder myofascial pain, secondary to injuries sustained from playing football for the National Football League from 1992 to 2001.
5. History of bilateral knee myofascial pain, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.
6. Left hip myofascial pain, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.
7. History of bilateral joint effusions and signal changes within his patella cartilage and subchondral bone, consistent with patella chondromalacia, indicated on bilateral knee MRIs obtained on 08/19/91, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.
8. Status post examination of his left knee under anesthesia with diagnostic arthroscopy, chondroplasty, and patellofemoral articulation, performed on 08/22/91 by Dr. Peter Indelicato, secondary to patellofemoral pain syndrome with probable severe degenerative changes of his patellofemoral articulation with recurrent effusions, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.
9. History of anterior horn medial meniscus tear, indicated on MRI of his left knee obtained on 01/23/92, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.
10. Status post left knee arthroscopy with arthroscopic plica excision, performed by Dr. Peter Indelicato and Dr. Richard Vlasak on 02/14/92, secondary to grade II/III chondromalacia of his patella with superomedial plica of his left knee, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.
11. History of moderate thinning of his articular cartilage of the median ridge of his patella, indicated on MRI of his left knee obtained on 10/05/92, made symptomatic secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.
12. History of pectoralis major and possible latissimus dorsi strain, secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.
13. History of tubular accumulation of fluid in his subscapular fossa interposed between the posterior-superior surface of the subscapularis muscle and the scapula with multiple septations within the fluid with irregularity of his inferior glenoid labrum, indicated on MRI of his right shoulder obtained on 07/30/93, made symptomatic secondary to injuries sustained while playing football for the National Football League from 1992 to 2001.

RBM 05/14/2015